The Black Sheep

SIR,—Dr. John D. Kershaw's letter (*Journal*, March 16, p. 645) prompts me to point out that the time and place to educate potential food-handlers, and everyone else, in the importance of food hygiene is at school. Until we have reasonably sanitary conditions in our schools and in our homes—that is, until children can be taught to practise cleanliness during the most impressionable years of their lives—it is futile to hope that any sort of laws can make people clean in later life.—I am, etc.,

Truro. V. E. WHITMAN.

Domiciliary General Practice

SIR,—It was with interest that I read Dr. R. N. Theakston's article on domiciliary general practice in prevention and treatment of illness (*Journal*, March 23, p. 696), but cannot agree with his practice of leaving perineal and vaginal tears for 24 hours before attempting any repair.

Perineal and vaginal tears are surely best repaired as soon as possible after delivery. In this way there is less time for the introduction of sepsis into the wound, and the patient is spared the nervous anxiety and apprehension which otherwise occur during the hours that elapse before the repair is carried out. After a mother has successfully weathered the experiences of labour she deserves the service of being tidied up completely, without having to anticipate the process of stitching in 24 hours' time. Carried out immediately after delivery, under local infiltration with 1% procaine, the repair is quickly performed, and the freshly damaged tissue is easily sutured.

Dr. Theakston may prefer to "suture the repair in comfort" some 24 hours later, but surely it is more kind, and certainly more scientific, to carry out the repair immediately, allowing the patient to recover sitting in physical and mental comfort.—I am, etc.,

Brompton-on-Swale, Yorkshire. UGO N. PHILLIPS.

Underfeeding of Babies

SIR,—The second paragraph of Dr. Ian G. Wickes's letter under this title (*Journal*, March 23, p. 702) should be reprinted, framed, and a copy hung in a prominent position in every maternity and paediatric unit. The habit of ascribing the cause of excessive crying to overfeeding is even more widespread than Dr. Wickes suggests, and his remarks might possibly—I use the word advisedly—make some slight impression on the iron prejudices of many senior nurses. My own practice in these cases is to listen in silence to the report, write out on the back of the chart the words "You cannot overfeed a baby" in capitals, and hand it over without comment. I have little illusion about its reception, but regard it as the drop of water which may eventually dent the stone.

Perhaps it is all our own fault in leaving nearly all the care of new babies to nurses. Many practitioners, perhaps the majority, are untrained or uninterested in paediatrics. If so, they should say so and direct the parent elsewhere. The consultant paediatrician is much too senior to be bothered with trivia, and yet these are often the despair of the young mother. So she falls back on the maternity nurse or nanny, who, however expert at the job she was trained for, is given a responsibility beyond her qualifications. This dependence on nurses may go to extreme lengths, and indeed some have extensive paediatric practices, travelling from house to house, advising on every sort of infantile disorder.

Whether this is a desirable state of affairs may be disputed, but many mothers feel that they are entitled to medical rather than nursing advice on their multiple problems, and it is surely the duty of the profession to provide it. Probably the ideal method would be the provision of a great many more "baby doctors," as distinct from consultant paediatricians. It is unreasonable to expect the latter to be concerned with the minutiae of infant life, but it is equally so to leave these unregulated. The "baby doctor"—a trained paediatrician willing to carry out a sort of general practice amongst infants—is an institution in several Continental countries and the U.S.A., and the few practising here are obviously only partly filling a widespread need.

The work done at infant welfare clinics is generally of a very high order, and covers the bulk of the infant population, but it cannot provide the almost daily supervision in the home which minor ailments often require, and which can only be effectively carried out by the sort of paediatrician I have described above.—I am, etc.,

London, W.1. ALBERT DAVIS.

Subacute Bacterial Endocarditis

SIR,—In their important contribution Drs. F. G. Hobson and Dr. B. E. Juel-Jensen (*Journal*, December 29, 1956, p. 1501) ask if subacute bacterial endocarditis due to *Str. viridans* ever occurs in an edentulous patient. The following case history may provide an answer.

A water board engineer, aged 59, was admitted to hospital on February 4 this year. He had been edentulous since 1942, when a total extraction had been done "for toothache." Five weeks before his present admission he had complained of pains in his head and back, and his doctor, finding a raised temperature, had ordered him to bed and had treated him for a few days with sulphonamides and later, again for a short period, with penicillin. The fever had initially responded to these treatments but had recurred when the drugs were withdrawn. There was no past history of rheumatism, and the patient denied any tendency to sore throat or to nasal catarrh.

On admission the patient, of moderate build, had evidently lost weight. He had a muddy pallor and was anaemic (Hb 45%). Temperature 101° F. (38.3° C.); pulse regular, 100. The apex beat was displaced towards the anterior axillary line. There was an apical systolic thrill, and a systolic murmur could be heard at the apex and also in the first interspace to the right of the sternum. The spleen was palpable. The urine contained pus cells and red blood cells. Leucocyte count, 6,700/c.mm.; neutrophils, 78%; lymphocytes, 19%; monocytes, 2%; eosinophils, 1%. Within 24 hours of admission three blood cultures were taken and each grew *Str. viridans*. Thereafter the patient was treated with penicillin, 1,000,000 units being given six-hourly. Within four days of treatment he was afebrile, and remained so throughout the six weeks during which he had penicillin, and at the time of writing there is no sign of relapse. On February 13 *x*-ray screening showed the large left ventricle and calcified valve shadows of aortic stenosis. My colleague, Mr. G. W. Vincent, has seen this patient and the *x*-rays of his jaws, and confirms that there are no dental remnants.—I am, etc.,

Wolverhampton. J. V. S. ARLINGHAM DAVIES.

Hospital Confinement

SIR,—The grounds for hospital confinement should be: (1) social—to be investigated by the M.O.H.; (2) medical—to be investigated by the doctor responsible for the patient. Each case should be dealt with on its merits. A general practitioner (especially that now so many have the D.R.C.O.G.) should be in a position to decide if a hospital confinement is necessary at the first booking or if it becomes so later. This would obviate the "blind" categories used as a result of statistics and would lessen the number of normal deliveries blocking beds in hospital.—I am, etc.,

Plymouth. O. LL. LANDER.

SIR,—Dr. Aileen M. Dickins and her colleagues (*Journal*, March 16, p. 645) ask for views on their remarks on hospital confinements. It is right that hospitals should persuade patients to stay at home. No hospital service could otherwise accommodate all those seeking admission for confinement. It is the duty of the general practitioners to select patients requiring admission, using the criteria that Dr. Dickins *et al.* suggest.